



Office of Health Facilities

Application for Community Residential Facility for the Intellectually Disabled

Reference Guide for New Applicants

Let's begin!

Log In to the platform

1 Enter your username and password.

2 Click the Log In button.

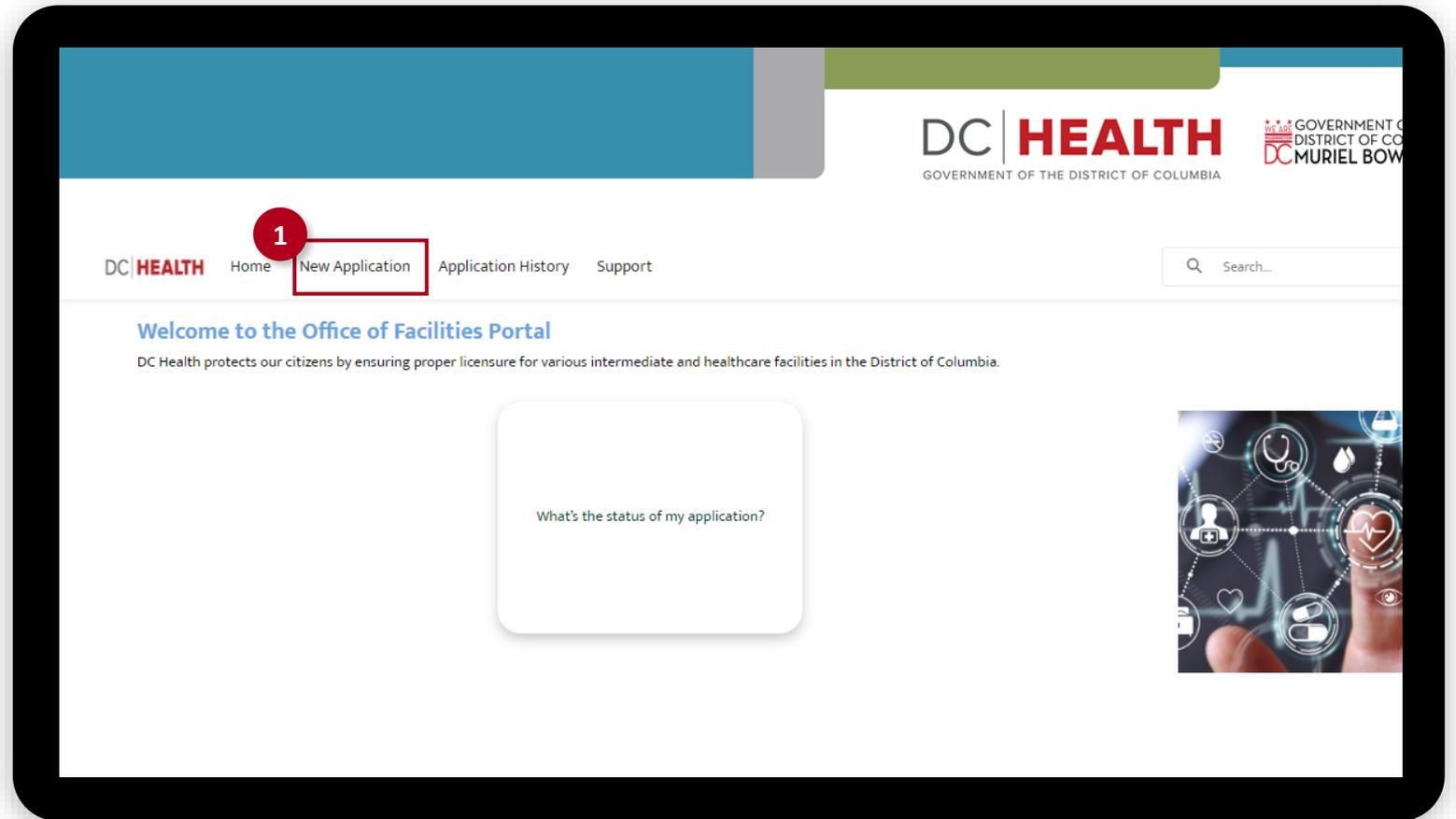


TIP: If you don't have an account click the **Create New Account** link.

The screenshot shows the DC Health login interface. At the top right, the DC Health logo and the Government of the District of Columbia logo with Mayor Muriel Bowser's name are visible. The main content area features the DC Health logo, a 'Welcome to the Office of Health Facilities Portal' message, and a list of actions under 'Login or Create an Account to:'. A red box highlights the login form, which includes a username field (containing 'TestUser17'), a password field (containing dots), and a blue 'Log in' button. Red callout circles with numbers 1 and 2 point to the username field and the 'Log in' button, respectively. Below the login form are links for 'Forgot your password?' and 'Forgot username?'. To the right of the login form is a 'Create New Account' link. Further right, there is an 'About DC Health' section with a brief description of the organization's mission and responsibilities.

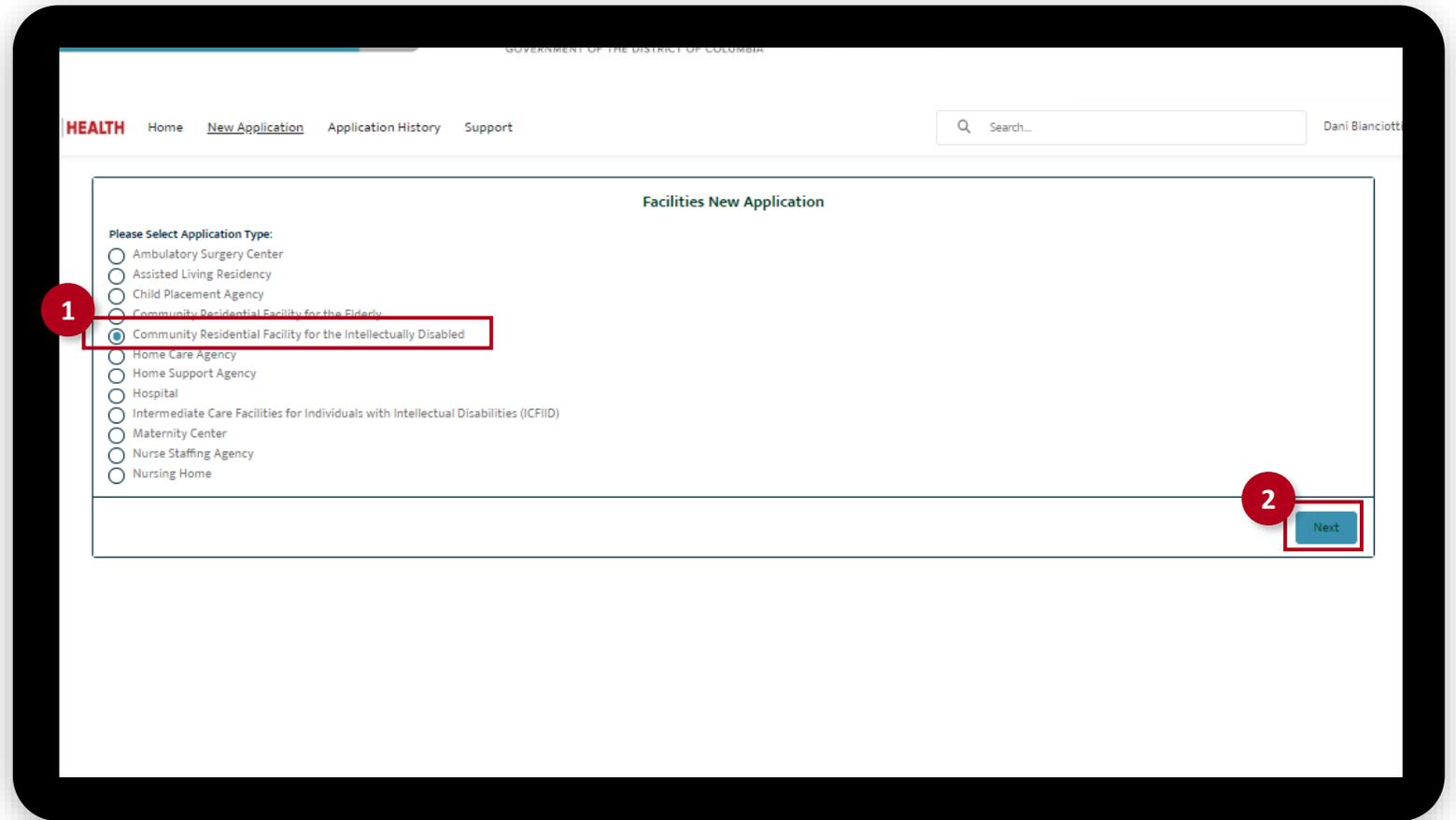
Navigate to the New Application screen

- 1 Once you Log in to the Office of Facilities Portal, click the **New Application** tab.



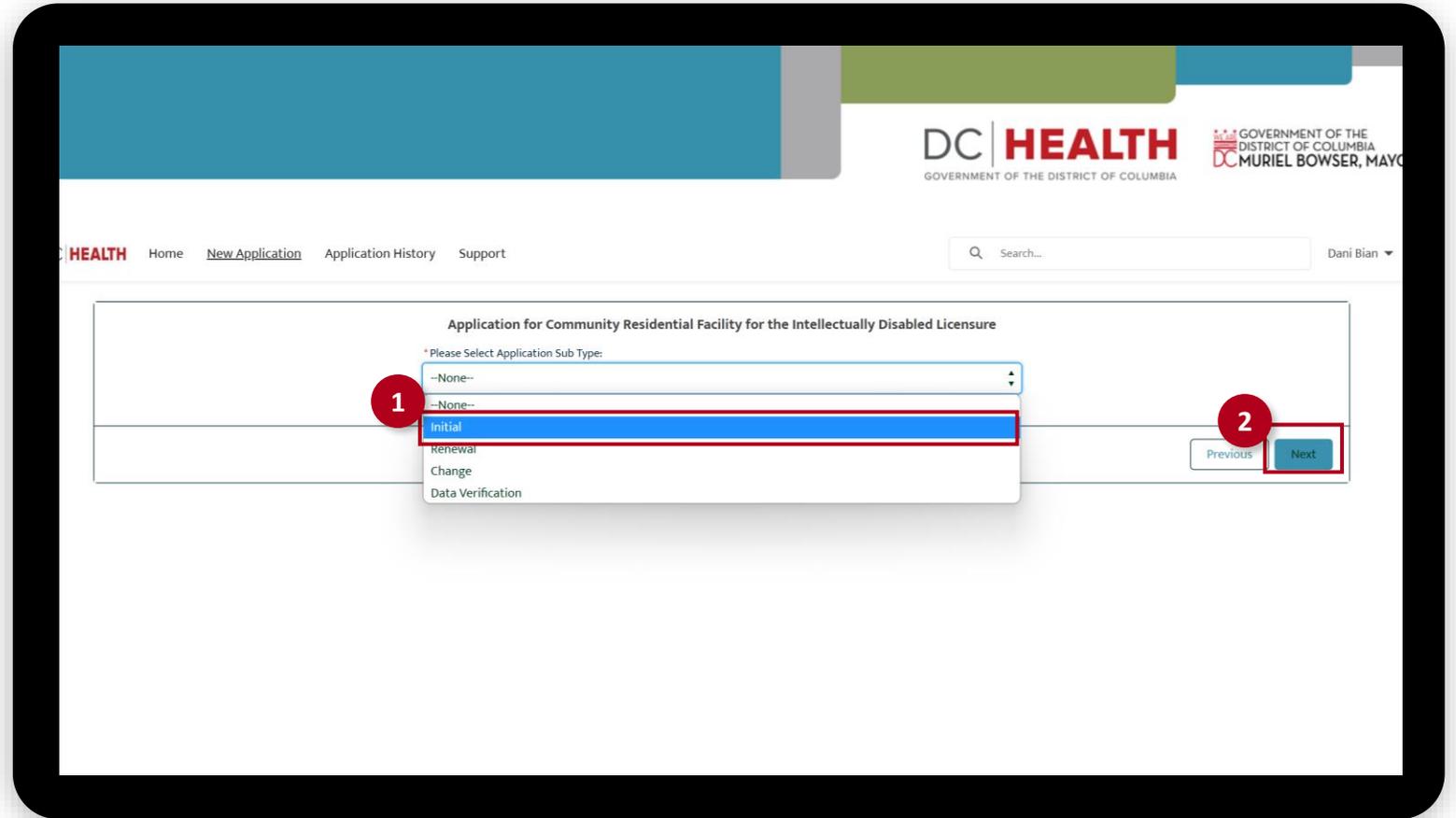
Select the Facilities New Application

- 1 Select the Community Residential Facility for the Intellectually Disabled option from the list.
- 2 Click the Next button.



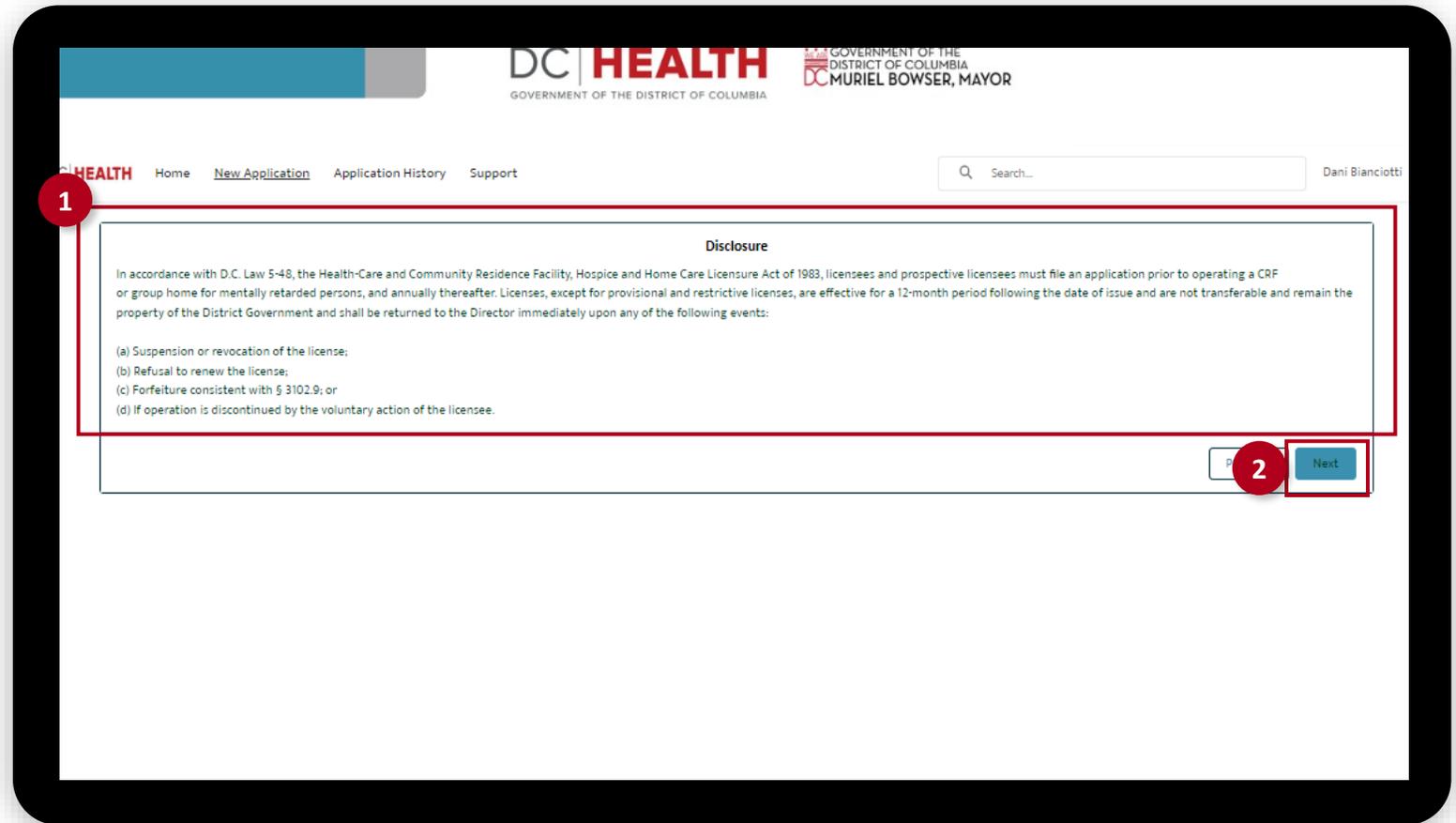
Select the Application Sub Type

- 1 Select the **Initial** option from the drop-down list.
- 2 Click the **Next** button.



Accept Disclosure

- 1 Read the Disclosure text.
- 2 Click the Next button.



Fill out the Facility Information

- 1 Fill out all the required fields.
- 2 Click the **Save & Next** button.

The screenshot shows a web form titled "Facility Information" with the following fields:

- * Type of Facility: --None--
- * Facility Name: Verda Daugherty
- * City: DuBuqueburgh
- * Zip Code: 45581
- * Fax Number: 495
- Is Mailing Address different?
- Website (if applicable): Quas natus ab sint a.
- * Number of Beds: 50
- * Males: 20
- * Do you provide 24 hour nursing care?: Yes
- * Street Address: 377 Santino Villages
- * State: MI
- * Telephone Number: 009-790-4860
- * Relationship of licensee to facility: Owner
- * Females: 10
- * Number of rotating Direct Support Staff: 10

A "Save & Next" button is located at the bottom right of the form.

The fields marked with * are mandatory and must be filled out to continue.



TIP: If the mailing address is different from the information filled out in the Facility fields, select the **Is Mailing Address different?** check box.

Fill out the Licensee Information

The licensee is the legal entity who has the ultimate responsibility and authority for the conduct of the facility.

- 1 Fill out all the required fields.
- 2 Click the **Save & Next** button.

DC HEALTH Home [New Application](#) Application History Support

Ut in ex debitis labore sapiente fugiat iusto. Dani Bianciotti

1

Zip Code: 10920 State: VT

Business Owner Address:

* Address: 941 Kling Terrace * City: Marloutown

* State: WY * Zip Code: 01148

* Profit or Non-Profit?: Non-Profit

* Business Type: Sole Proprietorship

* Have you previously operated or been licensed to operate a group home/CRF in the District of Columbia? Yes

If yes, was the license ever suspended or revoked? No

If yes, provide explanation.

* Is there any license application, Notice of Infraction or enforcement action pending as a result of your operation of a business in the District of Columbia? No

If yes, provide explanation.

Upload Files Or drop files

2 Save & Next

 **TIP:** If needed, use the **Upload Files** button to attach needed documentation.

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Principals/Officers Information

1 Fill out all the required fields.

2 Click the **Save & Next** button.

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Q Aperiam aut enim est non omnis laboriosam animi dolor Dani Bianciotti

Name the principals/officers of the licensee: (such as, CEO, President, VP, Secretary, Treasurer, Director)

1 **Principal/Officer of the Licensee - 1**

* First Name Middle Name * Last Name
Marcus Eulalia Harvey Shields

* Street Address * City
10752 Nicolas Ville Marquardtton

* State * Zip code
WY 14032

* Telephone Number * Email
602-353-2735 your.email+fakedata90390@gmail.com

* Title
Product Configuration Strategist

Add more Principal/Officers?

2 Save & Next



TIP: If needed, select the **Add more Principal/Officers?** check box and complete the fields with the required information.

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Facility Staffing Information

1 Fill out all the required fields.

2 Click the Save & Next button.

The screenshot shows a web form titled "Facility Staffing" on the DC Health portal. The form is divided into several sections. A red box highlights the main form area, and a red circle with the number "1" is placed at the top left corner of this box. At the bottom right of the form area, there is a blue button labeled "Save & Next" with a red circle and the number "2" next to it. The form contains the following fields:

- Residence Director:**
 - * Prefix: Ms. or Mrs. (dropdown)
 - * Name: Shanny Mayer
 - * Title: Investor Markets Consultant
 - * Highest Level of Education Completed: Gerlach LLC
 - * Name of Qualified Mental Retardation Professional (QMRR): Chaz Smith
- Other Professionals on Staff, if applicable:**
 - Director of Nursing: Tressie Lebsack
 - Primary Care Physician(s): Maudie Deckow
 - Licensed Practical Nurse(s): Abelardo Mayer
 - Trained Medication Employee(s): Immanuel Bergnaum
 - Live-In Staff: Noah Kertzmann

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Insurance Coverage Information

- 1 Fill out all the required fields
- 2 Click the **Save & Next** button.

The screenshot shows the 'Insurance Coverage' section of a web form. A red box highlights the form fields, with a red circle containing the number '1' at the top left and another red circle containing the number '2' at the bottom right. The form is divided into two sections: 'Hazard (Fire and extended coverage)' and 'Liability Insurance'. Each section has several input fields for Agency Name, Street Address, City, State, and Zip Code, along with a field for the amount of coverage. The 'Professional Liability (Explain)' field contains placeholder text. At the bottom of the form, there is an 'Upload Files' button and a 'Save & Next' button.

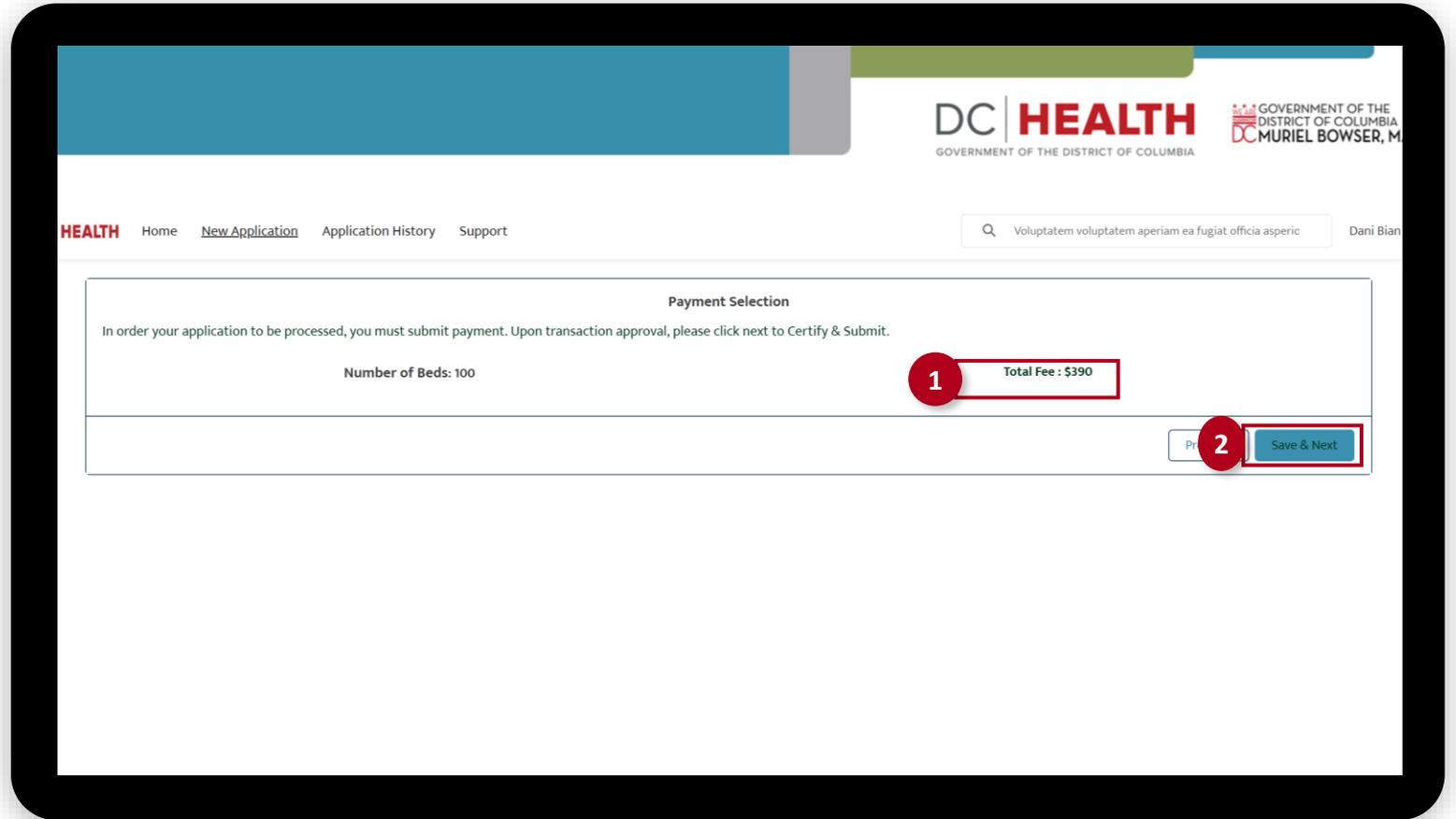
 **TIP:** If needed, use the **Upload Files** button to attach needed documentation.

The fields marked with * are mandatory and must be filled out to continue.

Payment Selection

The Total Fee depends on the number of beds filled out in the Facility Information screen.

- 1 Check if **Total Fee** is correct.
- 2 Click the **Save & Next** button.



Payment Wizard



1 Fill out the **Billing Address** and **Payment Info** fields.

2 Click the **Pay** button.

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Provident aut ratione qui earum praesentium facere asp Dani Bianciotti

Payment Wizard

Please complete the payment for your application using the form below. Click "Pay" when you are done inputting your payment details. If you are unable to pay at this time, you may exit this saved draft and return to it in the "Application History" tab of the portal header later.

After your payment has processed, click "Next" below to certify and submit the application. Your application will not be reviewed until these steps have been completed.

Billing Address	Payment Info
300 Wyman Coves	Donnell Rath
479 Kiera Rest	3782 822463 10005
Fort Lorenz	10 / 25
Kansas ?
59371	

Pay \$260.00

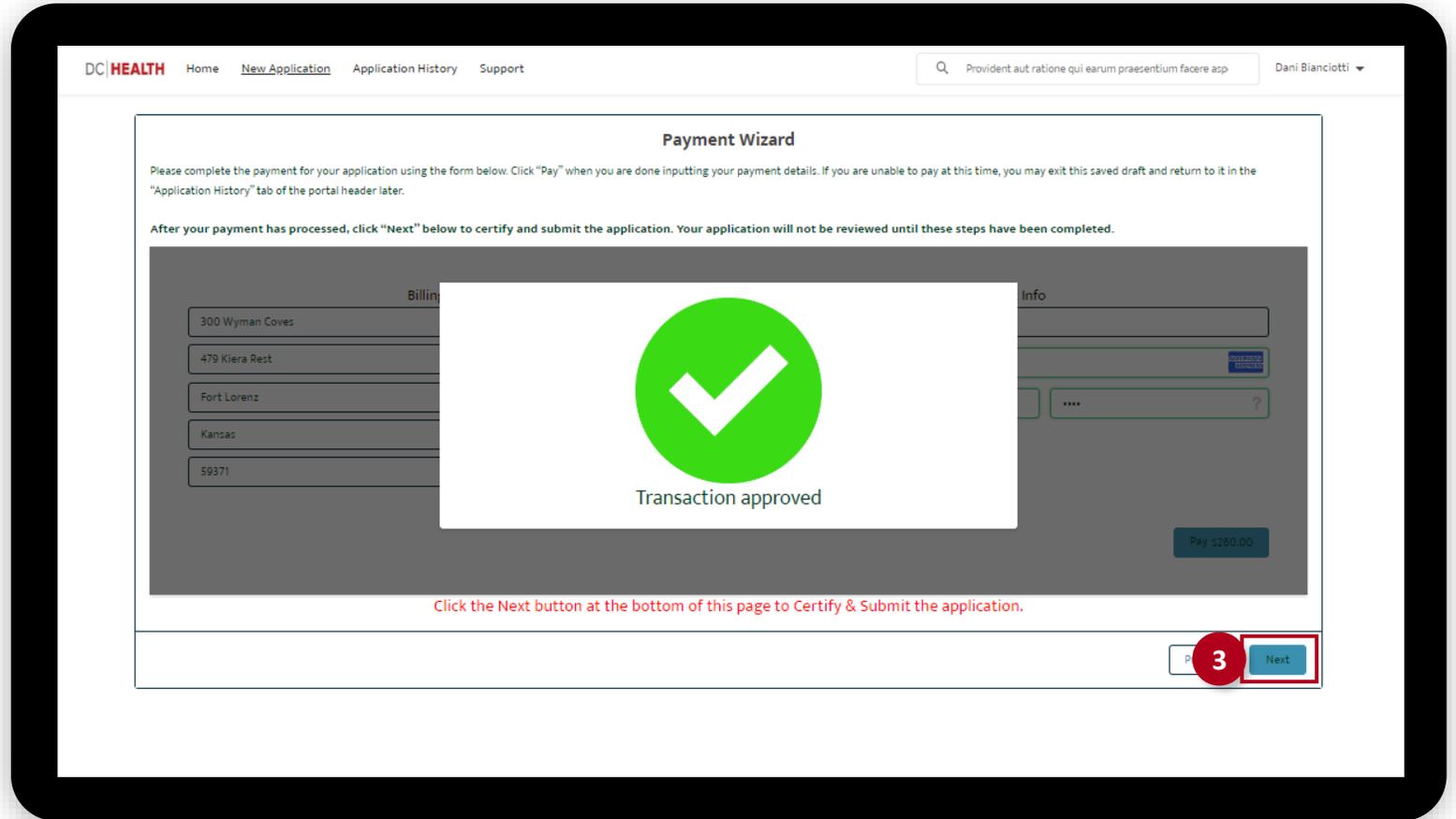
Click the Next button at the bottom of this page to Certify & Submit the application.

Previous Next

Payment Wizard



- 3 Once the Transaction is approved, click the **Next** button.



Certify and Submit

- 1 Fill out the Name field.
- 2 Click the Submit button.

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DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MA

Cupiditate sapiente quia quaerat impedit nemo est elige

Dani Bian

Certify and Submit

By clicking the submit button below, you are acknowledging that you are providing information for an official record and that the information you are supplying is true. By submitting this information, you understand that knowingly and willfully making a false statement on an official record may result in action against your license, registration, or certification and criminal penalties*. This information will be held confidential by the Department of Health.

*(a) A person commits the offense of making false statements if that person willfully makes a false statement that is in fact material, in writing, directly or indirectly, to any instrumentality of the District of Columbia government, under circumstances in which the statement could reasonably be expected to be relied upon as true; provided, that the writing indicates that the making of a false statement is punishable by criminal penalties or if that person makes an affirmation by signing an entity filing or other document under Title 29 of the District of Columbia Official Code, knowing that the facts stated in the filing are not true in any material respect or if that person makes an affirmation by signing a declaration under § 1-1061.13, knowing that the facts stated in the filing are not true in any material respect;

(b) Any person convicted of making false statements shall be fined not more than the amount set forth in § 22-3571.01 or imprisoned for not more than 180 days, or both. A violation of this section shall be prosecuted by the Attorney General for the District of Columbia or one of the Attorney General's assistants.

By electronically entering my name on this form, I attest that all statements are true and accurate.

* Name
Krystel Cassin

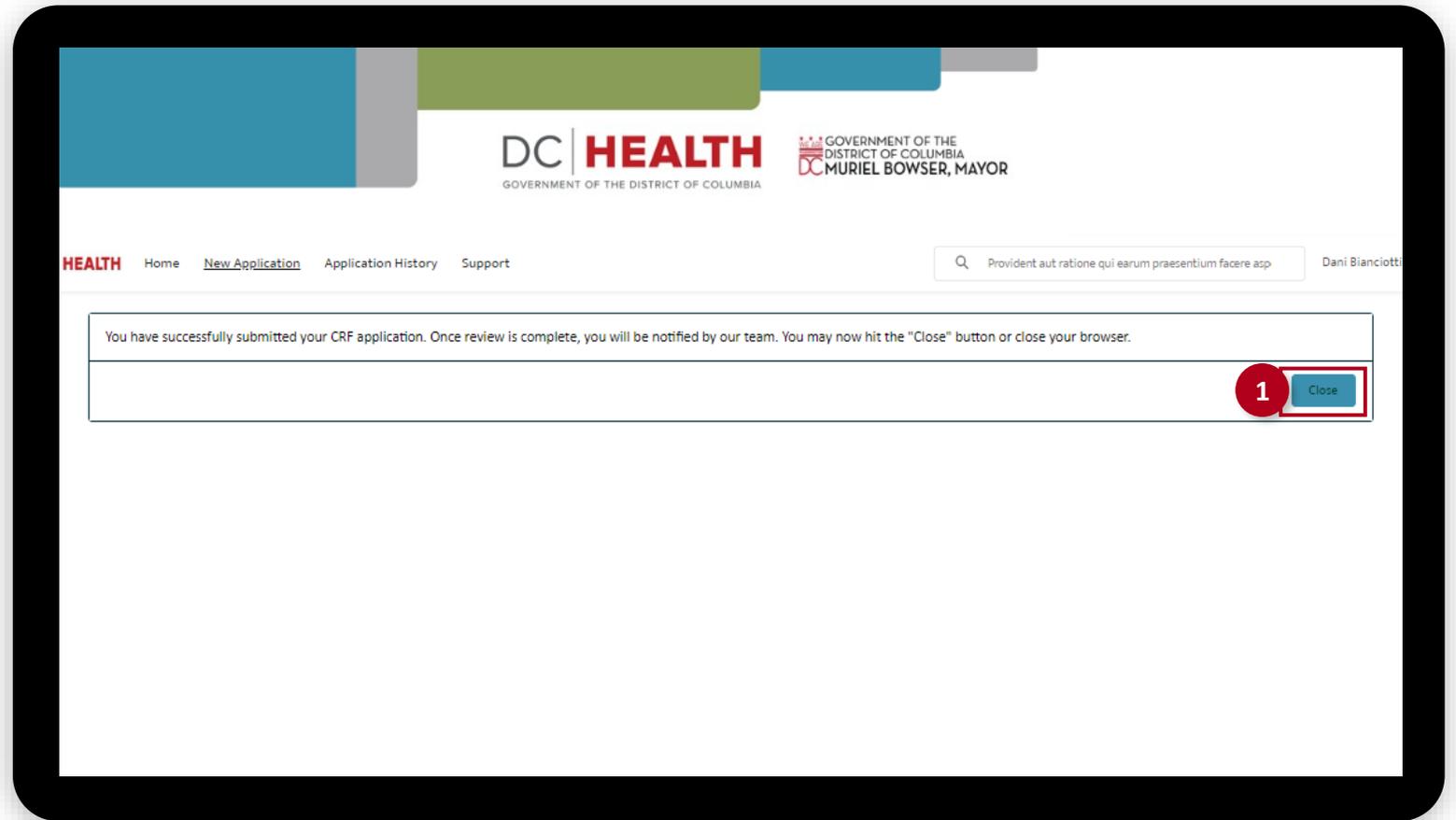
Date
January 24, 2023

Submit

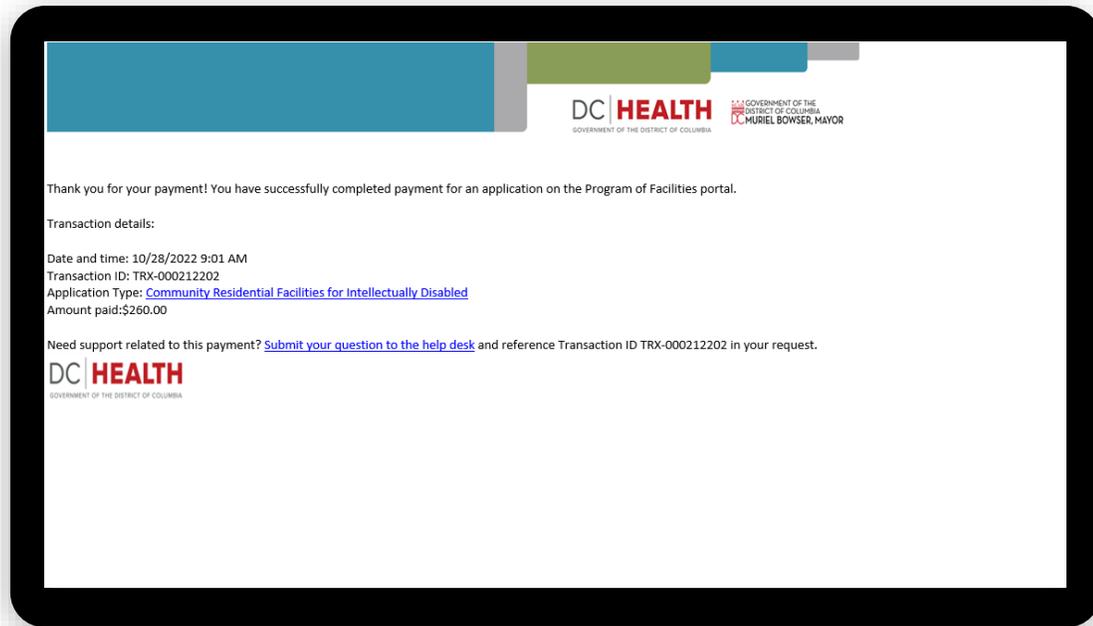
The fields marked with * are mandatory and must be filled out to continue.

Close the Application

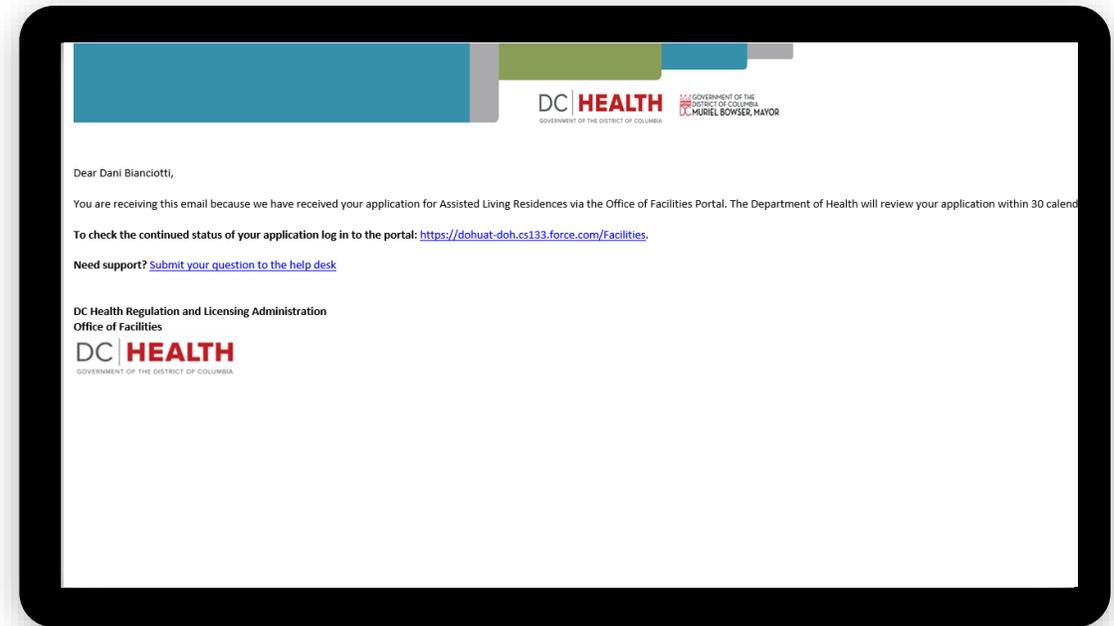
- 1 You have finished submitting your application. Click the **Close** button.



E-mail Confirmation



1 Check if you have received confirmation of payment.



2 Check if you have received confirmation for your application.

Thank you!